

## APPLICATION FOR ASSISTANCE

### Welcome to the Department of Health & Human Services (DHHS), Division of Family Assistance (DFA)

This is your application for the programs and services we offer. Please read all of the information given to you, and answer all of the questions as best as you can. **Do not answer anything that you do not understand.** If you need help in filling out this application, tell us. **We will accept your application even if you only fill in your name, address, signature, and program(s) requested.** DFA assistance is based on your income. Some DFA programs may also look at the cash value of things that you own, your “resources,” when figuring out if you qualify for a program DFA offers. Some resources, such as the home where you live, are not counted. Your Family Services Specialist (FSS) will explain which resources are counted.

#### Food Stamps

The Food Stamp Program helps low-income people buy the food they need for good health. You will need to complete an interview with an FSS to see if you are eligible for this program. **Your benefits are based on the date you give us an application.**

With identification, you may get emergency food stamps within 7 calendar days if:

- you have less than \$150 in monthly gross income and no more than \$100 in liquid resources;
- you have shelter costs that are higher than your gross income and liquid resources; **or**
- you are a migrant or seasonal farm worker who is destitute as defined in 7 CFR 273.10(e)(3).

#### Social Security Numbers (SSN)

The Federal Privacy Act of 1974 requires that we tell you the laws that allow us to ask for the Social Security Numbers (SSN) of each person requesting assistance, whether you are required to give them to us, and what we will do with them. SSNs are required for the following programs. After each program is the Public Law that requires us to ask for these SSNs.

- NHEP/FAP: Section 137 of Federal Public Law 92-603.
- Food Stamps: Section 4 of Federal Public Law 96-58.
- Medical Assistance and other financial assistance: Section 2651 of Federal Public Law 98-369.

Each person who wants assistance from the above programs, must provide an SSN or apply for a number at the Social Security Administration. If you are applying only for some members of your family, such as a parent applying for Medical Assistance just for a child, you only have to give us the child's number or apply for one for your child. Your child's eligibility for medical coverage will not be affected if you don't give us your SSN.

If an SSN is not provided for each person who is applying for the listed programs, your application may be denied or you may get less benefits.

#### Applicants for Healthy Kids Silver Premium Program do not have to provide an SSN.

We ask for SSNs so we can share earned and unearned income and resource information between DHHS and:

- the Social Security Administration;
- New Hampshire Employment Security;
- the Internal Revenue Service;
- financial institutions; and
- other computer matching programs.

This information may be shared with various offices within DHHS as allowed by federal law, used to determine or redetermine eligibility for or amount of benefits, identify or verify any errors in your eligibility and benefits, or used in an investigation of suspected abuse of program law or rules.

We do not give SSNs or any other information regarding non-applicants to the Bureau of Citizenship and Immigration Services (BCIS), formerly known as INS, or any other agency not directly connected with programs and/or services offered by DHHS.

*In accordance with Federal Law and USDA & U.S. HHS policy, DHHS is prohibited from discriminating on the basis of race, creed, color, sex, age, political affiliation or beliefs, religion, national origin, or mental/physical disability. For more information, call 1-800-852-3345 ext 6941.*

*TDD/TTY Access: Relay NH 1-800-735-2964*

### Emergency Medicaid for Non-Citizens

Emergency Medicaid may be available to certain non-citizens, regardless of their immigration status, to cover some emergency services, including labor and delivery. ***Social Security Numbers are not needed to apply for Emergency Medicaid.***

### Citizenship & Identity

You must declare the citizenship or non-citizenship status of each household member applying for assistance. Cash Assistance and Medicaid applicants must verify identity and citizenship or non-citizenship status for all household members who do not provide a U.S. Passport, a Certificate of Naturalization, or a Certificate of U.S. Citizenship. Non-citizens applying for assistance, except Emergency Medicaid, must provide BCIS documentation of qualified alien status. BCIS documentation will be verified.

### Third Party Insurance or Medical Payments

If you are applying for Medical Assistance or Healthy Kids Gold, receipt of such assistance is an assignment to DHHS of your rights to all third party insurance or medical payments without anyone having to sign any other form. All available parties must be billed and all resulting payments must be applied to the cost of medical care before DHHS will pay. Also, if you receive a settlement or an award from a liable third party, you must pay DHHS back for related medical services we paid. RSA 167:14-a.

### Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether we made a mistake in processing your case or you made a mistake in the information you provided, or failed to provide, to us.

### Financial or Medical Child Support

If you are applying for TANF cash payments, your receipt of such assistance is an assignment to DHHS of your rights to financial child support. Without signing any other form, you give DHHS the right to collect and keep financial child support payments made on behalf of your children who receive assistance. RSA 161-C:22

DHHS collects and keeps the support to partially offset the amount of cash assistance paid to you. If support payments are equal to or more than the amount we give you, your cash assistance case will be closed and the support payments sent to you.

Receipt of Medical Assistance for children is an assignment of medical child support rights. This means that you must cooperate with DHHS to establish and enforce medical child support for your children. Medical child support usually means health insurance provided by the absent parent, but can also be an ongoing dollar amount paid by the other parent to allow you to buy health insurance for your children.

If you receive money to purchase insurance, this money will be kept by the State while you receive Medicaid and will be used to pay back the state and federal governments. If paternity is not established for any of your children who are getting Medicaid, you must also cooperate with DHHS to legally establish paternity.

The assignment of support rights is a requirement. Your rights and responsibilities and the penalty for refusal without a good reason, will be explained to you when you meet with your Family Services Specialist.

### Begin Date for Medicaid Eligibility

Your Medicaid eligibility generally begins on the day that you meet all the requirements for the program you applied for, including the resource limit.

### AGENCY USE ONLY

This is your record of application and will be filled out by a Department of Health and Human Services worker and returned to you. DFA has received a completed application for \_\_\_\_\_ from \_\_\_\_\_ on \_\_\_\_\_

District Office

Signature of Worker

Referred for XFS ☐ Yes ☐ No  
Initials: \_\_\_\_\_

**A. Please tell us about who you are and where you live.**

Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
(if different)  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Message: \_\_\_\_\_  
Does anyone in your family have Medicare Part A or B? ☐ Y ☐ N Are You Homeless? ☐ Y ☐ N  
Why do you need our help? \_\_\_\_\_  
Information Supplier: \_\_\_\_\_  
(if different from applicant) Name Address Phone #

**B. Please tell us about the people you live with. Start with yourself and list ALL of the people living with you.**  
*You do not have to give the Social Security Number or citizenship status of any individual who is not applying for assistance.*

| Name: | U.S. Citizen?   | SSN: | Date of Birth: | Relation to you: | RID<br>(Agency Use Only) |
|-------|---|------|----------------|------------------|--------------------------|
| 1.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                | SELF             |                          |
| 2.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                |                  |                          |
| 3.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                |                  |                          |
| 4.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                |                  |                          |
| 5.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                |                  |                          |
| 6.    | <input type="checkbox"/> Y <input type="checkbox"/> N |      |                |                  |                          |

**C. I want to apply for: (TYPES OF ASSISTANCE REQUESTED)**

☐ Nursing Home Care

THE FOLLOWING PROGRAMS: ☐ ALL PROGRAMS ☐ Cash ☐ Medical Assistance  
☐ Food Stamps ☐ Child Care ☐ Medicare Buy-In Programs (QMB/SLMB)

**D. Please tell us about all income for everyone in your home.**

Your Wages: \$ \_\_\_\_\_ ☐ Weekly ☐ Bi-Weekly ☐ Monthly  
Other Wages: \$ \_\_\_\_\_ ☐ Weekly ☐ Bi-Weekly ☐ Monthly  
Other Wages: \$ \_\_\_\_\_ ☐ Weekly ☐ Bi-Weekly ☐ Monthly  
Has anyone recently lost a job? ☐ Yes ☐ No  
If yes, who? \_\_\_\_\_ When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SSA/SSDI: \$ \_\_\_\_\_ Spousal Support: \$ \_\_\_\_\_  
SSI: \$ \_\_\_\_\_ Unemployment: \$ \_\_\_\_\_  
VA: \$ \_\_\_\_\_ Child Support: \$ \_\_\_\_\_  
Pension: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

**E. Please tell us about all assets for everyone in your home.**

Checking/Savings: \$ \_\_\_\_\_ Other Chk/Save: \$ \_\_\_\_\_  
Stocks/Bonds/CD's: \$ \_\_\_\_\_ IRA: \$ \_\_\_\_\_  
Your or Your Spouse's Annuity: \$ \_\_\_\_\_ Other Assets: \$ \_\_\_\_\_  
Trusts: \$ \_\_\_\_\_ Life Insurance: \$ \_\_\_\_\_  
Vehicle (Yr/Mdl): \_\_\_\_\_ Vehicle (Yr/Mdl): \_\_\_\_\_

**F. Your Expenses:**

Rent (monthly): \$ \_\_\_\_\_  
Mortgage (monthly): \$ \_\_\_\_\_  
Lot Rent/Condo Fee (monthly): \$ \_\_\_\_\_  
Taxes (yearly): \$ \_\_\_\_\_  
Dependent Care: \$ \_\_\_\_\_  
Medical Expenses: \$ \_\_\_\_\_

**Do you pay for the following utilities separate from your rent or mortgage?**

Heat: ☐ Yes ☐ No  
Phone: ☐ Yes ☐ No  
Electric: ☐ Yes ☐ No  
Other: ☐ Yes ☐ No

**PLEASE COMPLETE THE BACK**

| AGENCY USE ONLY:             |      |       |        |             |                      |  |  |  |  |
|------------------------------|------|-------|--------|-------------|----------------------|--|--|--|--|
| RFA: _____                   |      |       |        |             | Date Received: _____ |  |  |  |  |
| Forms Given: 725 177 AW9 253 |      |       |        |             | Other Forms: _____   |  |  |  |  |
| FANF AP                      | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| FANF MA                      | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| ADULT AP                     | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| QMB/SLMB                     | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| FOOD STAMPS                  | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| HKG/HKS/MCPW                 | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| CHILD CARE                   | OPEN | CLOSE | DENY   | DATE: _____ | DO: _____            |  |  |  |  |
| EBT Card Status:             |      | None  | Active | Deactivated | Cancelled            |  |  |  |  |

**G. POTENTIAL ELIGIBILITY QUESTIONNAIRE**

|  |  |
|--|--|
| 1. Are you a migrant or seasonal farm worker?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you or anyone in your household received Food Stamp assistance for this month?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are you currently living in a shelter for battered individuals?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Is anyone in your household blind or disabled?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you sold or transferred property in the last 5 years?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Is anyone in your household currently receiving assistance from another State?<br>If yes, which State? _____ What kind of assistance? _____                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Is anyone in your household pregnant or has anyone given birth in the last 3 months?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you have any unpaid medical bills from the past 3 months that you would like help paying?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. If you are applying for Financial Assistance to Needy Families, is the father's name blank or "not stated" on the birth certificate for any of your children? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. If applying for Financial Assistance to Needy Families, how many absent parents?   | _____  |
| 11. Do you or any other household member have health insurance other than Medicaid?<br>If yes, name of Insurer? _____ Policy Number _____                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**H. The following information is collected to be sure that everyone is served fairly. Your answers are voluntary. The information provided will not affect your eligibility or benefit amount.**

Are you Hispanic or Latino? ☐ Yes ☐ No

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Are you: White? ☐ Y ☐ N Black or African American? ☐ Y ☐ N Asian? ☐ Y ☐ N  
 Native Hawaiian or Other Pacific Islander? ☐ Y ☐ N American Indian or Alaskan Native? ☐ Y ☐ N

**I. SIGNATURES**

I certify, under penalty of perjury, that I have reviewed this information; it is true and complete to the best of my knowledge, including the information concerning citizenship and alien status. I understand a full eligibility interview may be conducted before my eligibility can be determined.

Applicant: \_\_\_\_\_  
 Signature Date

Other: \_\_\_\_\_  
 Signature Date Relationship to Applicant

I withdraw my application for: ☐ Cash ☐ Medical Assistance ☐ Food Stamps ☐ Child Care ☐ Nursing Home Care ☐ Medicare Buy-In

\_\_\_\_\_  
 Signature Date

I certify that I have given the above individual(s) the opportunity to review this application. I also certify that I have provided a copy of this form, if one was requested.

\_\_\_\_\_  
 Family Services Specialist Signature Date

## APPLICATION: YOUR RIGHTS AND RESPONSIBILITIES

### Time Limits

You can only receive Financial Assistance to Needy Families for 60-months in your lifetime. Months you received this assistance while you were a child do not count towards the lifetime limit. Your time limit begins when you receive benefits as an adult. **There is no time limit on State Supplement Programs, Medical Assistance, Food Stamps, or child care assistance.**

### Nondiscrimination Notice

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers. Or you may also write Ombudsman, NH DHHS, 129 Pleasant St., Concord, NH 03301-3857; or call (603) 271-6941 or 1-800-852-3345 ext 6941. TDD Access: Relay NH 1-800-735-2964.

### Administrative Appeal

You or someone representing you may request an Administrative Appeal if you are not satisfied with any decision regarding eligibility made by DHHS. You may be represented by an attorney or other person at an Administrative Appeal. DHHS will not pay for the cost of any legal services. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant Street, Concord, NH 03301-6521. Telephone (603) 271-4292 or 1-800-852-3345 ext 4292; TDD Access: Relay NH 1-800-735-2964.

### Quality Control

Your case may be selected for a quality control or other governmental review. Such a review entails an in-depth investigation into your household's financial or medical situation, living arrangements and other circumstances. We may be contacting banks, employers, companies, merchants and other appropriate sources, concerning your household and statements you made to DHHS. **Failure to cooperate in these reviews could result in the loss of your benefits.**

### Reporting Changes

You will be required to periodically complete a review of your circumstances. Your cash assistance and Food Stamp case could be closed, and/or your eligibility for Medical Assistance may be affected, if you do not completely fill out the form and return it by the due date and come in for a personal interview, if required.

If you only get Food Stamps and you have a 4, 5, or 6-month eligibility period, you only need to report those changes in household circumstances that would place your household's income above 130% of the poverty level.

If you receive cash assistance, child care assistance, Medical Assistance, or if your Food Stamp eligibility period is not 4, 5, or 6 months, then you must notify the Department within 10 calendar days after the change happens for changes in:

- source of income;
- hours worked by a household member;
- amount of income of any member in your household;
- assistance group or household composition;
- resources (e.g., cash, stocks, bonds, or money in a bank or savings account);
- receipt of any lump sum payment or settlement;
- residence, or shelter costs; or
- child care costs, child support payments or medical deductions, or other changes that may affect the amount of your household's benefits.

### Protection of Medical Assistance for Social Security Beneficiaries

If you are receiving cash assistance under the OAA, ANB, or APTD program, and a Social Security cost-of-living increase or this increase combined with an increase in other income makes you ineligible for financial assistance, you may still be entitled to Medical Assistance under the Pickle Amendment policy.

Once you begin receiving Medical Assistance under the Pickle Amendment, future Social Security cost-of-living increases will not affect your eligibility. However, other changes in your circumstances can still make you ineligible for Medical Assistance.

If you are eligible to receive money payments under one of the above programs, but choose not to receive a payment, you will **NOT** be entitled to this protection of your Medical Assistance under the Pickle Amendment.

### ATTENTION!

The information that you tell us and provide in this application will be subject to:

- verification by federal, state and local officials; and
- computer matching with other agencies.

We do this to confirm your eligibility for our programs and determine your benefits. If any information is found to be inaccurate, you may be denied assistance and may be subject to criminal prosecution for knowingly providing false information. Any member of your household who breaks any of these rules on purpose can be prohibited from participating in the cash assistance and Food Stamp programs for periods ranging from one year to permanently. In the Food Stamp Program, you can also be fined up to \$250,000, imprisoned up to 20 years, or both, and will be subject to prosecution under the applicable state and federal laws for violations of the Food Stamp Act.

### Notice to Immigrant Families

If you get help with health care or Food Stamps, it will not affect your immigration status. If you or members of your family used or received Medicaid, Healthy Kids, or Food Stamps, it will not affect your or your family members' ability to become U.S. citizens.

However, if you get cash assistance such as TANF or help with the cost of nursing home care, it might create problems with becoming a U.S. citizen, especially if the benefits are your family's only income. Before you apply, you may want to talk with an agency that helps immigrants with legal questions or contact the U.S. Bureau of Citizenship and Immigration Services (BCIS).

### DO NOT

- **Do not** give false information or hide information to get or continue to get benefits.
- **Do not** trade or sell Food Stamp benefits to anyone who is not authorized to use them for your household.
- **Do not** use Food Stamp benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- **Do not** use any benefits your household was not entitled to receive.

### Identity & Residence

Anyone convicted of making a fraudulent statement or representation with respect to identity or residence in order to receive benefits in two locations at the same time will be ineligible for financial assistance and food stamps for 10 years.

### Trafficking Food Stamps

Any person who is found guilty in a court of law for buying or selling illegal drugs or certain prescription drugs in exchange for Food Stamp benefits, will be prohibited from participating in the Food Stamp program for 24 months for the first offense and permanently for the second offense. Any person who is found guilty in a court of law for buying or selling ammunition, firearms or explosives in exchange for Food Stamp benefits, or of any trafficking in Food Stamp benefits of more than \$500, will become permanently ineligible for Food Stamp benefits.

### Medical Assistance Fraud

Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with your application for or receipt of Medical Assistance benefits.

A person may be prosecuted in Federal Court for deliberate statements that are known to be false and which affect eligibility for any benefit or payment under the Medical Assistance program.

A person may also be prosecuted for concealing or failing to disclose any event that affects their right to any benefit or payment, or its conversion to a use other than intended. The law also provides a penalty for a kickback, bribe, or rebate in connection with the furnishing of Medical Assistance.

Conviction of an offense could result in loss of Medical Assistance benefits for a period not to exceed 1 year. Penalties are fines up to \$25,000 or imprisonment for not more than 5 years, or both.

### Intentional False Statements

Any person who intentionally makes a false statement or misrepresents his or her circumstances or intentionally fails to disclose the receipt of property, wages, income or resources or any change in circumstances that would affect his or her initial or continued eligibility for assistance may be found guilty of violating state law. The penalties are: a class A felony where the value of the monetary award or goods or services exceeds \$1,000; a class B felony where the value exceeds \$100; and a misdemeanor where the value does not exceed \$100. RSA 167:17-b and 17-c.

APPLICATION: STATEMENTS OF UNDERSTANDING

INITIALS

**I certify** that I have reviewed the information I have provided in this application, and it is true and complete to the best of my knowledge.

**I certify** that I have received a copy of "Your Rights and Responsibilities," and I understand them.

**I understand** that the Department will keep any information on this application confidential and only persons involved in administering the Department's programs or as otherwise permitted by Federal regulations or State law will review it.

**I understand** that I may have to provide documents to prove what I have written on the application or stated to my caseworker.

**I understand** that the information I have provided will be verified by Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud.

**I understand** that as part of the administration of Department programs, the Department may verify information I have provided on this application or stated to my caseworker which would affect my eligibility. My signature below authorizes the Department to obtain verification and authorizes release of such information to the Department. My authorization to release information remains in effect until the time of my next redetermination of eligibility.

**I certify** that the Domestic Violence Option has been explained to me, and I understand it.

**I certify** that I have received written information about the treatment of lump sum income if I applied for Financial Assistance to Needy Families.

**I understand** that my receipt of financial assistance under the TANF Program is an assignment to the Department of each recipient's rights to child and spousal support.

**I understand** that if my request for financial assistance is approved by the Department, the amount of assistance I receive could cause my food stamp benefits to end or be reduced. I also understand that if this happens, I will not receive advance notice of this change.

**I understand** that if anyone in my household is fleeing to avoid prosecution of a felony crime, or if anyone ever violates conditions of probation or parole, that person will be permanently ineligible for Financial Assistance to Needy Families or food stamp benefits. My signature below is my sworn statement that no one in my household at this time is fleeing felony prosecution or violating conditions of probation or parole.

**I understand** that the use of my Electronic Benefits Transfer (EBT) card for food stamp or financial assistance benefits is controlled by my 4-digit Personal Identification Number (PIN), that I am responsible for the security of my EBT card and PIN, and that EBT benefits will not be replaced if someone else uses my card after I have activated it.

**I understand** that if I do not use my EBT card to withdraw my Food Stamp benefits for a period of 365 days, any remaining benefits that are older than 365 days will be removed from the account and will no longer be available for spending. I understand that if I do not use my EBT card to withdraw my financial assistance for a period of 90 days, any remaining benefits that are older than 90 days will be removed from the account and no longer available for spending.

**I understand** that for food stamp benefits, to receive a deduction for receipt of child care expenses, rent or mortgage payments, utility or other shelter expenses, child support paid to a non-household member, or medical expenses (only for the elderly or disabled), I must report and provide verification to my caseworker. Failure to report or verify any of the above listed expenses, or of receipt of fuel assistance, could mean that I will receive less food stamp benefits each month, and will be seen as my statement that my household does not want to receive a deduction for the unreported or unverified expense.

**I understand** that my receipt of medical assistance is an assignment to the Department of my rights to all third party medical insurance or payments.

**I understand** that my receipt of medical assistance means the Department must be able to obtain medical records from medical providers. My signature below authorizes my family's medical providers to release any records to the Department.

**I understand** that, if I am in a nursing home, the Department must be able to exchange eligibility information with the nursing home to best administer the program. My signature below authorizes that exchange and remains in effect until the time of my next redetermination.

**I understand** that for long-term care services (Nursing Facility or Home and Community-Based Care), I am required to disclose to the Department any interest that my spouse or I have in any annuity.

**I understand** that if either my spouse or I are requesting long-term care services, any annuity purchased or modified by my spouse or me on or after February 8, 2006 will be considered a transfer of assets for less than fair market value unless the State is named the beneficiary for at least the amount of Medicaid paid for long-term care services.

I certify, under penalty of perjury, that I have reviewed this information; and it is true and complete to the best of my knowledge.

**Applicant**

Signature

Date

**Other**

Signature

Relationship to Applicant

Date

I certify that I have given the above signed individual(s) the opportunity to review this document, and that I have completely explained and given them a copy of the Rights and Responsibilities Notice. I also certify that I have given them a copy of this page, if it was requested.

**Employee**

Signature

Title

Date